Local Projects of the World Psychiatric Association Programme to Reduce Stigma and Discrimination

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The World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia, which was launched in 1996, has established projects to fight stigma in 20 countries, using social-marketing techniques to enhance their effectiveness. This article describes some of the strategies used and the lessons learned in implementing two local antistigma projects. At each site the first steps were to establish an action committee and to conduct a local survey of perceived stigma. On the basis of the survey, the local action committee selected a few homogeneous and accessible target groups, such as students, employers, and criminal justice personnel. These smaller groups were targeted, because focusing on the general public is expensive and unlikely to have a measurable impact. Messages for the target groups and the media used to reach them were carefully selected, tested, and refined. The author gives examples of the work that was done with such target groups as high school students and the criminal justice system. Guidelines are provided for setting up a consumer speakers' bureau, which is valuable for addressing target groups. The bureau can be made up of people who have experienced mental illness, family members, and mental health professionals. Guidelines are also provided for establishing a media-watch organization, which can lobby news and entertainment media to exclude negative portrayals of people with mental illness. Organizers of local projects should be on the lookout for useful changes that can become permanent, such as changes in the curriculum for high school students or for police officers in training. Projects such as these can be effective in reducing stigma and can be relatively inexpensive. (*Psychiatric Services* 56:570–575, 2005)

Efforts have been made since the 1950s to reduce the prejudice toward people with mental illness (1,2). Despite these attempts, stigma (3,4), discrimination (5), and misconceptions about mental illness continue to be pervasive (6–13). Citizen-driven not-in-my-backyard campaigns obstruct the placement of residential facilities (14,15). The perception of stigma by people with psychosis is associated with enduring negative effects on their self-esteem, well-being, mental status, work status, and income (16,17). Public and professional opinions about mental illness adversely affect its detection and outcome (18–22). Both the 1999 U.S. Surgeon General's Report (23) and the 2001 WHO World Health Report (24) cite stigma as one of the greatest obstacles to the treatment of mental illness.

In the past decade we have seen an increase in the will to combat stigma. We have also seen the application of a new tool, social marketing, to this task. This article describes how two sites of the World Psychiatric Association (WPA) Programme to Reduce Stigma and Discrimination Because of Schizophrenia—Calgary, Alberta, and Boulder, Colorado—harnessed this tool to combat stigma.

Social marketing

Social-marketing campaigns have been used successfully around the world in AIDS prevention, smoking cessation, and many other causes (25). Effectiveness is increased by audience segmentation—that is, partitioning a mass audience into subaudiences that are relatively homogeneous and devising appropriately targeted promotional strategies and messages (26). In developing such campaigns, it is useful to conduct a needs assessment that gathers information about the groups' cultural beliefs and the media through which they could best learn about the topic. The needs assessment may incorporate focus groups, telephone surveys, or information from opinion leaders. Specific objectives, audiences, messages, and media are selected, and an action plan is drawn up. The messages and materials are pretested with audiences and revised. The plan is implemented and, with continuous monitoring of impact, constantly refined (25).

Implementing a local antistigma program

The WPA global antistigma program, launched in 1996 (27), has established projects to fight stigma in 20 countries and has created a process

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for setting up antistigma projects in local communities that follows these steps: establish a local action committee, conduct a survey of sources of stigma, select target groups, choose messages and media, and evaluate the impact of interventions, while continuously refining them. A detailed account of this process is available at www.openthedooors.com.

Establishing a local action committee

The composition of the action committee is critical in establishing a local project. Committee members should include representatives of groups that the campaign is considering targeting; however, these groups will not be known when the action committee is formed. Therefore, the initial planning group should select committee members from walks of life that are likely to become target groups, such as the police, employers, or clergy, and add members later as needed. Some of the most valuable members of the action committee will be consumers and family members, who have a firsthand understanding of discrimination.

Members of the action committee must be willing to devote substantial time to the project, as most of the work will be accomplished by their volunteer effort. It is valuable to include prominent citizens, such as legislators, on the committee. For example, when requesting a meeting with the editorial board of the local newspaper, the inclusion of someone with name recognition increases the impact of the request. Prominent individuals may have less time to commit and can be given affiliate status.

An action committee should comprise ten to 20 members—neither so small as to burden members with too much work nor so big as to be unwieldy. A large group can split into task forces to refine action plans for different target groups. Action committees commonly meet monthly, distributing minutes and an agenda at each meeting.

Selecting target groups

It is helpful to conduct a survey of local consumers, family members, and others to determine where stigma is seen to be prevalent—for example, in emergency departments or among employers. The action committee can use this information to select a manageable number of target groups, probably no more than three. It is inadvisable to target the general population. To do so is expensive and unlikely to have a measurable impact. In the Calgary project, random pre-post telephone surveys revealed that a radio campaign targeted at the general public produced no change in attitudes toward or knowledge of mental illness (28). Target groups should be homogeneous and accessible. For example, landlords are not an accessible group because they do not meet as a group or use a common media outlet.

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Employers are more accessible because the project can identify the largest local employers and target their human resource departments. The police are also an accessible group, because they receive regular inservice training.

Action plans

The action committee develops an action plan that includes specific goals and objectives for each target group. The goals might include, in increasing order of difficulty, developing awareness, increasing knowledge, changing attitudes, and changing behavior—for example, reducing discrimination in housing. For a target group such as high school students, the goals might be to increase awareness of stigma, increase knowledge about schizophrenia, and reduce stigmatizing attitudes. To meet these goals, measurable objectives might include giving a presentation about stigma and mental illness to 50 percent of the students in the district, achieving 25 percent improvement in the average scores on mental illness knowledge and a 10 percent reduction in the average scores on social distance among participating students. (Social distance refers to the respondents' expressed preference regarding their association with people with mental illness.)

Objectives should be realistic, so project members are not disappointed by small gains. On the basis of the project's goals and objectives, the action committee can select key messages and determine the media that will be used to distribute the messages. The action plan should specify who will accomplish each step and by what date. A program planner is available at www.openthedoors.com.

Target groups

Working with schools

High school students are a popular target group in the WPA global antistigma program; this group has been selected by at least a dozen projects, from Calgary to Ismailia, Egypt. The popularity of this target group has less to do with the likelihood that students will stigmatize people with mental illness and more to do with their ready accessibility and the opportunity to influence the attitudes of a coming generation. When meeting with school principals, project members can frame the effort to reduce stigma as an important component in diversity training and point out that mental illness is often neglected in health education.

Examples of messages that were used in the high school antistigma programs in Calgary and Boulder include "No one is to blame for schizophrenia," "People with schizophrenia are *people* with schizophrenia," and "Watch your language"—that is, don't use derogatory terms to refer to people with mental illness.

Media that were used included

speakers with mental illness, the Web page of the WPA program (www.openthedoors.com), a teaching guide on schizophrenia (available on the Web page), and an art competition for students to produce antistigma materials.

To mount the art competition in Boulder, organizers obtained the support of the school principals and art teachers. A consumer speakers' bureau and a project coordinator with a background in visual arts made presentations in art classes. The presenters announced a juried competition, with money prizes, for students to produce artwork dealing with stigma and mental illness. (Some of the entries can be viewed by going to www.mhcbc.org and clicking on Anti-Stigma Project.) A public art show with an awards ceremony was mounted after each annual competition, and an exhibit of all the entries was displayed in participating high schools.

The impact of a social-marketing campaign is increased if the target group receives the same message from different sources (the media multiplier effect) (29). In Boulder, interior bus advertisements reach a predominantly younger audience and are free for public-service announcements. The WPA project in Boulder installed several bus advertisements with antistigma messages, including one that used student art with the statement, "Sometimes those that are different are the most amazing." Cinema patrons are also predominantly younger people. The Boulder project ran slides with three different antistigma messages among the advertisements that preceded the main feature on 16 local cinema screens. One message read, "Don't believe everything you see at the movies: mental illness does not equal violence." Exit surveys revealed that 18 percent of cinema patrons recalled the content of at least one of the three messages displayed. Thus, during three months of displaying the slides, more than 10,000 people would have been able to recall one message two hours after seeing it. The total cost was 36 cents for each person who recalled seeing a message, which compares very favorably with usual commercial media costs (30).

Outcomes from high school interventions have been positive throughout the WPA project. In Calgary more than 3,000 students participated in the intervention. Post-testing was conducted at different times, from minutes to weeks after the intervention, depending on the classroom. The proportion of students who answered all the questions about mental illness correctly increased from 12 to 28 percent on pre-post testing and the proportion who expressed no social distance between themselves and someone with schizophrenia increased from 16 to 30 percent (24). (An example of a social distance question is "Would you be upset to be in the same class with someone with schizophrenia.") In Vienna positive changes in attitudes were evident three months after the intervention (31). At three sites in Egypt students were tested about their knowledge about schizophrenia and its treatment before and after the intervention. The students' scores doubled after the intervention, and the proportion of students who believed that someone with schizophrenia would be likely to commit a crime decreased from 56 to 29 percent (32). In Leipzig, Germany, students were tested about their attitudes toward a person with schizophrenia; scores improved substantially during a three-month follow-up in the group of 90 students that received the intervention but not in the control group of 60 students (33).

Working with the criminal justice system

Criminal justice personnel are underrecognized partners in the management of mental illness. The police bring people who are acutely disturbed into care or protective settings. Jail officers struggle to manage people with acute psychosis in environments that are totally unsuited to the task. Judges wrestle with the disposition of mentally ill offenders. Probation officers supervise people with mental illness, even though the officers do not have access to consultation about the person's capacity to respond to directives. Yet there are few programs that attempt to provide criminal justice personnel with the education necessary to perform these essential parts of their jobs. For this reason, the Boulder antistigma project, and other WPA program sites, selected criminal justice personnel as a target.

Police training. Mental health professionals, consumers, and police officers collaborated in developing a one-day, eight-hour pilot training course, which was pilot tested with seasoned officers and rookies in the county's largest city (population 100,000). Applying lessons learned from pre-post testing in the pilot program, the project undertook the training of the entire police department in the county's second largest city (population 70,000). To minimize the disruption of police services to the community, the training was delivered six times, to a portion of the department's officers each time, at change of shift in the afternoon or evening before the officers went on duty.

The training, an abbreviated form of the pilot course, comprised two, two-hour sessions on adult and child disorders and was presented by psychiatrists, consumers, and their family members. The content included the features, course, treatment, and outcome of psychotic disorders; the diagnosis of childhood disorders; myths about schizophrenia; the diverse characteristics of people who attempt suicide; and a discussion of why people with psychosis should not be kept in jail. The classes discussed why people with borderline personality disorder are often not admitted to a hospital. This topic is important if the training is to be successful, because police officers everywhere are likely to complain about bringing someone in for evaluation after a suicide attempt, only to learn later, as commonly phrased, "She got home before I did!"

Pre-post testing of the officers conducted immediately before and after the training, revealed no improvement in attitudes toward people with psychosis, but it revealed a 48 percent improvement in scores of knowledge about adult and child mental disorders. The proportion of officers who held inaccurate beliefs about the causes of schizophrenia fell from 24 to 3 percent, but another

misconception scarcely changed. The proportion who held a mistaken belief about the usual behavior of people with schizophrenia fell only from 82 to 71 percent. After training, 71 percent of the officers still believed one or more of the following statements: people with schizophrenia are always irrational, much more likely to be violent than the average person, or usually unable to make life decisions. Officers retained these beliefs, even though they heard a presentation by a quietly eloquent, middle-aged woman with schizophrenia who was working full-time as a university library supervisor.

We subsequently realized that police encounters with people with psychosis nearly always occur when the person is acutely disturbed, and officers have little opportunity to meet people with schizophrenia who are working, in stable relationships, or rarely hospitalized. We concluded that police training must intensively expose officers to people who have recovered from psychosis if it is to effect attitudinal change. A model program that uses consumers to provide police training has been established in the WPA antistigma project in Kent, England (34). Subsequent police training sessions in Boulder County have ranged from four to seven hours in duration, have achieved modest improvements in attitudes and substantial gains in knowledge of mental illness, and will reach all the county's officers by the end of 2005.

To make the training available to police officers across Colorado and elsewhere, the Boulder project collaborated with the U.S. Department of Corrections to produce a training manual and PowerPoint presentation. This eight-hour training program, available from the author, can be delivered by professionals with a moderate level of expertise, consumers, family members, and police officers.

Judges, attorneys, and probation officers. Psychiatrists, people with mental illness, and family members provided three training sessions on adult disorders and one training session on child disorders to judges, attorneys, and probation officers (approximately 12 in each category). Nearly all the county judges attended. A pre-post test conducted directly before and after the training revealed that judges' accuracy of knowledge about schizophrenia improved from 47 to 74 percent, and some judges reported immediate changes in sentencing practice. After the training sessions were completed, the judges requested two more training sessions on juvenile disorders.

Setting up a consumer speakers' bureau

A speakers' bureau is valuable for addressing students, police, and other groups. It often comprises people who have experienced mental illness, family members, and a mental health professional whose function is to answer factual questions—for example, what causes schizophrenia? People with mental illness can react to the stress of public speaking by experiencing an increase in symptoms shortly after the event. To minimize this possibility, consumers with good tolerance of stress should be selected. They should be gradually introduced to speaking in front of audiences by first observing and then speaking briefly until they can participate fully without experiencing stress. Speakers should be debriefed after each presentation to learn what they found stressful. Several speakers should be trained so that the demand on any one person is not too great.

Speakers who are consumers demonstrate the reality of recovery, generating optimism and compassion. A study conducted in Innsbruck, Austria, revealed that high school students addressed by a psychiatrist and a consumer reported significant changes in social distance attitudes, whereas those who were addressed by a psychiatrist and a social worker did not (35). Other research has indicated that previous contact with someone with mental illness decreases stigma and fear of dangerousness (36,37). Consumers can talk about discrimination in employment, housing, and law enforcement, but they should try to avoid generating defensiveness in the audience.

The coordinator of the speakers' bureau can be a consumer, family member, or enthusiastic citizen. The coordinator should maintain a diary of engagements, select speakers for each event, debrief them afterwards, and ask the host to provide an assessment. The speakers and the coordinator commonly receive remuneration. A successful speakers' bureau—such as the Partnership Program operated by the Calgary branch of the Schizophrenia Society—will develop a strong sense of a shared mission, which is nurtured through regular meetings.

Setting up a media-watch group

Local and national advocacy groups can lobby news and entertainment media to exclude negative portrayals of people with psychosis. Such groups are known as "stigma-busters" or "media-watch" groups. A local antistigma project can establish the media-watch function in several ways. Members can inform national media-watch organizations about negative portrayals that are distributed nationally, respond to calls to action from national advocacy groups, and contact local media outlets about stigmatizing messages.

National media-watch bodies in the United States have become quite effective. The National Stigma Clearinghouse, which was begun in 1990 by the New York State chapter of the National Alliance for the Mentally Ill (NAMI), collects examples of negative portrayals of people with mental illness from a variety of U.S. media. Staff write or phone the journalists, editors, or others responsible for the negative portrayal, explaining why the material is offensive and providing accurate information about mental illness. In one instance the Clearinghouse was successful in getting DC Comics to change the story line that dealt with Superman's death, so that his killer was no longer "an escapee from an interplanetary insane asylum." The group distributes a monthly newsletter that summarizes recent actions and educates local advocates about the kinds of negative media portrayals to look for and how to correct them (38). NAMI has also used its national membership effectively to combat stigma. In 1999, in response to the airing of the TV series *Wonderland,* in which mentally ill people were seen committing numerous violent acts, NAMI coordinated a mail-

ing to ABC and the show's commercial sponsors. The program was pulled from the air after two episodes, even though 13 had been filmed.

Local action can also be effective. In Boulder County a local newspaper recently carried an advertisement for an apartment rental that depicted a man in a straitjacket with bulging eyes and distorted features; the advertisement included the text, "Driven crazy by cramped housing?" A polite letter to the advertiser, along with a copy to the newspaper editor, led to the immediate withdrawal of the advertisement and a letter of apology.

Local media-watch groups do not need to be large or complex. One or two coordinators can establish links to a broader group of members who report stigmatizing items. The coordinators forward items of national scope to a national media-watch group or respond directly to a local newspaper or business about local items. A gradual escalation approach is generally effective. Begin with a polite request, perhaps suggesting that the stigmatizing reference was inadvertent. A positive response should be rewarded with a letter of thanks. Often those guilty of the offense are appropriately concerned and may later become supporters of the media-watch group. If the offender is unresponsive, increasing pressure can be applied, such as writing a letter for publication in the local newspaper (38).

Funding and sustainability

Attempts to influence the general public through mass advertising are expensive and unlikely to prove effective, but targeted interventions, such as police training and classroom presentations, can be conducted and assessed with modest expense. Total expenditures during the first three years of the Boulder project were less than $10,000.

A local campaign cannot run forever (three years is a reasonable length of time), but permanent structures and partnerships can be developed. On the basis of experiences in Boulder, Calgary, and elsewhere, these might include changing the high school health curriculum to include mental illness, adapting school diversity programs to include education about mental illness, forming a consumer speakers' bureau, creating a media-watch group, and changing institutional policy, such as emergency department procedures for dealing with people with mental illness (39).

The project director should evaluate which components of the campaign will require ongoing funding and find support for these elements. Local advocacy groups or agencies may be willing to assume responsibility for some components.

Conclusions

Local antistigma projects should involve a broad array of community representatives in the planning and action committee. They should focus on a few specific target groups in which a change in knowledge, attitudes, or behavior would be likely to reduce discrimination and improve the quality of life of people with mental illness. The project should aim to establish some permanent changes that will allow sources of stigma to be monitored and modified on an ongoing basis. Attempts to target the general public are likely to be expensive and ineffective and are not encouraged. ♦

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References

1. Cumming E, Cumming J: Closed Ranks: An Experiment in Mental Health Education. Cambridge, Harvard University Press, 1957
2. Nunally JC: Popular Conceptions of Mental Health: Their Development and Change. New York, Holt, Rinehart, and Winston, 1961
3. Hall P, Brockington IF, Levings J, et al: A comparison of responses to the mentally ill in two communities. British Journal of Psychiatry 162:99–108, 1993
4. Brockington IF, Hall P, Levings J, et al: The community's tolerance of the mentally ill. British Journal of Psychiatry 162:93–99, 1993
5. Sayce L: Stigma, discrimination, and social exclusion: what's in a word? Journal of Mental Health 7:331–343, 1998
6. O'Grady TJ: Public attitudes to mental illness. British Journal of Psychiatry 168:652, 1996
7. Borinstein AB: Public attitudes towards persons with mental illness. Health Affairs 11(3):186–196, 1992
8. Weiner B, Perry RP, Magnusson J: An attributional analysis of reactions to stigmas. Journal of Personality and Social Psychology 55:738–748, 1988
9. Corrigan PW, River LP, Lundin RK, et al: Stigmatizing attributions about mental illness. Journal of Community Psychology 28:91–102, 2000
10. Link BG, Phelan JC, Bresnahan M, et al: Public conceptions of mental illness: labels, causes, dangerousness, and social distance. American Journal of Public Health 89: 1328–1333, 1999
11. Corrigan PW, Rowan D, Green A, et al: Challenging two mental illnesses stigmas: personal responsibility and dangerousness. Schizophrenia Bulletin 28:293–309, 2002
12. Thompson AH, Stuart H, Bland RC, et al: Attitudes about schizophrenia from the pilot project of the WPA worldwide campaign against the stigma of schizophrenia. Social Psychiatry and Psychiatric Epidemiology 37:475–482, 2002
13. Corrigan PW, Watson AC, Warpinski AC, et al: Implications of educating the public on mental illness, violence, and stigma. Psychiatric Services 55:577–580, 2004
14. Boydall KM, Trainor JM, Pierri AM: The effect of group homes for the mentally ill on residential property values. Hospital and Community Psychiatry 40:957–958, 1989
15. Repper J, Sayce L, Strong S, et al: Tall Stories From the Backyard: A Survey of "Nimby" Opposition to Mental Health Facilities Experienced by Key Service Providers in England and Wales. London, Mind, 1997
16. Link BG, Struening E, Rahav M, et al: On stigma and its consequences: evidence from a longitudinal study of dual diagnoses of mental illness and substance abuse. Journal of Health and Social Behavior 38: 177–190, 1997
17. Link BG: Understanding labeling effects in the area of mental disorders: an assessment of the effects of expectations of rejection. American Sociological Review 52:96–112, 1987
18. Hall P, Brockington I, Eisemann M, et al:

Tolerance of mental illness in Europe, in Psychiatry in Europe: Directions and Developments. Edited by Sensky T, Katona C, Montgomery S. London, Gaskell, 1994

19. Jorm AF: Mental health literacy: public knowledge and beliefs about mental disorders. British Journal of Psychiatry 177: 396–401, 2000
20. Link BG, Phelan JC, Bresnahan M, et al: Public conceptions of mental illness: labels, causes, dangerousness, and social distance. American Journal of Public Health 89: 1328–1323, 1999
21. Stuart H, Arboleda-Florez J: Community attitudes towards people with schizophrenia. Canadian Journal of Psychiatry 46:245–251, 2001
22. Magliano L, Fiorillo A, De Rosa C, et al: Beliefs about schizophrenia in Italy: a comparative nationwide survey of the general public, mental health professionals, and patients' relatives. Canadian Journal of Psychiatry 49:171–179, 2004
23. Mental Health: A Report of the Surgeon General. Rockville, Maryland, Center for Mental Health Services, National Institute of Mental Health, 1999
24. Mental Health 2001—Mental Health: New Understanding, New Hope. Geneva, World Health Organization, 2001
25. Rogers EM: Diffusion of Innovations. New York, Free Press, 1995
26. Rogers EM: The field of health communication today: an up-to-date report. Journal of Health Communication 1:15–23, 1996
27. Sartorius N: Fighting schizophrenia and its stigma: a new World Psychiatric Association educational programme. British Journal of Psychiatry 170:297, 1997
28. Stuart H: Stigmatisation: Leçons tirées des programmes de réduction. Santé Mentale au Québec 28:37–53, 2002
29. Smith A: Take a Fresh Look at Print, 2nd ed. London, International Federation of the Periodical Press, 2002
30. The Virginia-Pilot Advertising Department. Marketing Your Business: Cost per thousand. Available at www.adinsite.com/costperthousand.html
31. Ladinser E: Students and community psychiatry: changes in attitudes towards people with mental illness and community psychiatry resulting from an anti-stigma programme in schools. Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001
32. El-Defrawi MH, El-Serafi A, Ellaban M: Medical students' involvement in health education about schizophrenia: A campaign in secondary schools in Ismailia, Egypt. . Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001
33. Schulze B, Richter-Werling M, Matschinger H, et al: Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia. . Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001
34. Pinfold V: Working with the police. . Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001
35. Meise U, Sulzenbacher H, Kemmler G, et al: A school programme against stigmatization of schizophrenia in Austria. Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001
36. Link BG, Cullen FT: Contact with the mentally ill and perceptions of how dangerous they are. Journal of Health and Social Behavior 27:289–303, 1986
37. Penn DL, Guynan K, Daily T: Dispelling the stigma of schizophrenia: what sort of information is best? Schizophrenia Bulletin, 20:567–575, 1994
38. Wahl OF: Media Madness: Public Images of Mental Illness. New Brunswick, NJ, Rutgers University Press, 1995
39. Thompson AH, Bland RC: Canadian national standards for emergency rooms changed following WPA anti-stigma survey. Presented at Together Against Stigma conference, Leipzig, Germany, Sept 2–5, 2001